Washington State
Health Care Authority

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STRATEGIC PLAN

FISCAL YEAR 2005-2007

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Introduction

The Health Care Authority (HCA) was established in 1988 to administer state employee health care benefits, and to study and make cost-containment recommendations for state-purchased health care. In 1993, HCA's role was expanded to include the Basic Health and Community Health Services (CHS) programs that provide health care access to low-income populations. Since 1993, the agency role has been expanded to promote collaboration between state agencies that purchase health care services, and to increase access to affordable prescription drugs. In summary, HCA's mission is to help provide access to quality, affordable health care – both for the individuals served by HCA-administered programs, and indirectly, for clients and beneficiaries of other state-funded health care.

This Strategic Plan lays out the mission and vision for the Health Care Authority, as well as our strategic direction for the 2005-2007 biennium. It summarizes our approach to conducting business today, and our focus for the future.

The cost of providing access to comprehensive health care services is growing far faster than inflation – and far faster than employee wages and state tax revenues. This trend poses a major, long-term budget challenge – both for the state and for the individuals covered by HCA programs. Several factors are contributing to the cost trends – amazing advances in medical technology; increases in prescription drug prices and utilization; higher administrative and insurance costs; increases in chronic medical conditions, such as obesity and diabetes; the aging of the baby boomer generation; and increased use of medical/pharmacy services and products, in part due to consumer advertising, etc. In addition, studies by the Institute of Medicine [IOM] indicate that a significant portion of our health care expenditures result from inefficient care systems, poor quality care, and errors in the delivery of care.

These factors pose major challenges to HCA's mission: "to provide access to quality affordable health care." At the same time we address cost and quality challenges, we also recognize that providing access to health care means more than just paying to make doctors, hospitals, and other medical providers available. It also means providing access to information that enables individuals to make informed choices regarding their providers and medical care. HCA also takes seriously its responsibility to be a prudent steward of the public funds provided for its programs – to administer its programs as efficiently as possible while at the same time ensuring the integrity of its eligibility decisions and pursuing financial recovery efforts.

In this Strategic Plan, we identify our key goals and strategies for addressing health care cost trends, promoting health care quality and safety, expanding access to health care information, and increasing the efficiency of our administrative processes. Our top goal is to use our position as a major purchaser of health care coverage to leverage improvements in patient safety and the quality of health care services, and to reduce expenditures for inappropriate or poor quality care for the people covered by HCA programs, and indirectly for all residents of Washington State.

To address our financial stewardship responsibility, the Strategic Plan also lays out our plans to examine our business processes and to focus on core activities and services. We will review how we conduct business and incorporate technology improvements to better, and more efficiently, meet our changing customer requirements and expectations. In the long run HCA must focus our most valuable asset - our human resources - on those processes and services that make the greatest contribution to our mission.

HCA has a very important mission to fulfill for the residents of Washington State and a highly dedicated workforce to deliver on that mission. It is with pride that I present our strategic plan for the 2005-2007 biennium.

Pete Cutler
Acting Administrator, HCA

A: Agency Mission Statement

Mission: Provide access to quality affordable health care.

Vision: Deliver the best value in health care.

Values We will treat our customers and each other with respect, fairness, honesty, and consistency.

We will foster a climate in which innovation, initiative, and accountability are expected and supported.

We will work with our customers to improve our responsiveness in meeting their needs.

We will exploit technology and emphasize user-friendly interfaces.

We will encourage an atmosphere of honesty, integrity, dignity and excellence that is fostered in all aspects of agency activity.

We will recognize our employees' essential role in the success of the agency, and ensure that they are encouraged, supported and provided opportunities to grow.

We will build partnerships with providers, clinics, health care plans, and other agencies to provide our customers with the best service possible.

B: Statutory Authority

RCW 41.05.005(2)	Establishing the Health Care Authority
RCW 41.05.050 - 197	Public Employees Benefits Board Program
RCW 41.05.140	Uniform Medical Plan/Uniform Dental Plan
RCW 41.05.220	Community Health Services
RCW 70.47	Basic Health Plan
RCW 41.05.013	Uniform Policies regarding Evidence Based Medicine
RCW 41.05; 70.14; 69.41	Prescription Drug Program

C-D-E: Agency Goals, Objectives and Strategies

1) **Goal (Leadership):** We will be innovative in developing the best purchasing practices, and use our role as purchaser to leverage improvements in the health care marketplace.

   Objectives:
   - Develop purchasing strategies to improve efficiencies and control health care costs.
   - Ensure quality by encouraging best practices and preventive services through procurement and contract management.
   - Reduce administrative and other costs through interagency collaborative efforts, such as the consolidation of Medical Assistance Administration, HCA, and Labor & Industries purchasing and management of prescription drug coverage; and adopting standardized billing requirements and reimbursement policies.
   - Collaborate with other state health care agencies on evidence-based medical technology assessment and prevention policies.
   - Explore various options to promote member involvement and educate consumers to make better informed decisions regarding their health.
   - Collaborate and participate with the King County Task Force on future health care purchasing initiatives.

   Strategy: To ensure quality health care to enrollees, purchase and deliver health care based on best practices and provide consumer information and incentives to choose effective care.

2) **Goal (Customer Service):** Maximize customer access to health care, information, and exemplary services.

   Objectives:
   - Within existing resources, maximize access to all HCA programs.
   - Develop an online insurance system that will meld programs and processes to ensure effective customer contact and service delivery methods, including self-service capability, to improve core business functions.
   - Consider customer and employer impacts and needs when conducting business or developing processes.

- Protect HCA's customers' privacy and health care rights.

- Identify standards or benchmarks for the provision of cost-effective, appropriate, and accessible services and information; and for responsiveness of services.

Strategy: We will provide responsive, appropriate and accessible services and Information.

3) Goal (Financial Impact): We will practice sound business principles and financial stewardship.

Objectives:

- Make program and purchasing decision based on the value of health care as measured by quality and access relative to costs.

- Maintain high standards of financial accountability and cost-effectively administer public dollars.

- Improve internal and external control processes, such as the oversight of contracted services, the appropriateness of payments, and the integrity of program eligibility.

Strategy: We will assure that agency business processes are customer-focused, regularly evaluated for improvement, aligned with agency vision and values, and are meaningfully measured.

4) Goal (Internal Processes): Ensure that internal processes are designed to maximize customer services, and organizational efficiency.

Objectives:

- Increase reliance on electronic media.

- Ensure the integrity of core business functions such as HCA eligibility and enrollment processes.

- Implement surveys to establish baselines to increase internal customer satisfaction; use customer input in decision-making.

- Build collaborative relationships with business partners including vendors, health plans, and labor organizations.

Strategy: We will incorporate products, processes, and methodologies designed to improve business and organization efficiencies**.**

5) Goal (Learning and Growth – Value and Benefit): We will attract, develop, retain and reward a high-performing diverse workforce.

Objectives:

- Integrate the core competency model to maximize employees' effectiveness and accountability in meeting key business needs.

- Achieve positive trends in employee satisfaction with recognition.

- Design and implement civil service reform programs and policies that are flexible, fair, and responsive to changing business needs.

Strategy: We will demonstrate commitment to our employees by providing leadership, direction, development and opportunities for personal growth and participation in the achievement of organizational excellence.

F: Appraisal of External Environment

Increasing health care costs continue to impact the state's financial outlook. The cost of providing access to health care services continues to grow at an annual rate that far exceeds the general rate of inflation, and the state expenditure limit established by Initiative 601. While the state economy shows signs of improving, it is not expected to recover in the next decade from the impacts of the Boeing layoffs and "dot-com bust" of recent years.

The funding and administration of health care in this country have become increasingly complex and fragmented. Every year new medical treatments and technologies are developed, and new approaches are experimented with to extend health care to various uninsured populations. Our society has conflicting expectations – wanting access to the most advanced "medical miracles" and also wanting health care to be free, or nearly so. We also expect high quality, well-coordinated medical care, but also want to select from the widest possible number of providers, and to be able to change providers easily. Our society has a highly fragmented approach to funding health care services - with different covered benefits and cost-sharing arrangements for different populations, and constant changes to those services, covered benefits, and cost-sharing arrangements. This fragmentation results in very high administrative expenses that divert funding from direct medical care. However, changes to reduce the complexity and administrative expense are often resisted if they are perceived to reduce individual choice.

Prescription drugs costs are expected to continue double-digit growth trends, and the bio-med industry has products in the pipeline that will dramatically improve treatments, at a far greater cost. Reimbursement levels continue to be a source of tension for many providers – such as for hospitals that want to finance capital improvements, for certain specialist groups that have strong bargaining leverage; and for doctors and other providers that have to pay for insurance and for the staff and systems needed to manage increasingly complex billing provisions.

As the cost of providing health care services increases and society moves away from "managed care" as a means to control costs, most employers are increasing the amount paid by their employees for their health care benefits. Some employers are dropping coverage for some groups of employees entirely, while others are reducing funding for dependents or retirees. Grocery store employee unions in Southern California staged a four month strike in 2003-04 over this issue, and health care coverage is expected to be a major issue in major contract negotiations in Washington and Oregon in 2004.

The trend of increased employee cost-sharing for health benefits began in the private sector, but has spread to the public sector as well. Average employee premiums for PEBB plans have increased from approximately $14 in 1999 to $79 in 2004. In addition there has been a reduction in the number of health plans contracting with PEBB – from 16 in 1999 to seven in 2004. While the trend towards increasing employee cost sharing has been widespread, including the City of Seattle and King County, it has not been universal. Most employees of the State of Oregon do not pay member premiums for their individual coverage. The Governor will be engaged in full scope collective bargaining, including salaries and the employer's health insurance funding level, with state employee organizations in the spring and summer of 2004. Issues of health insurance benefit design are a permissive scope of bargaining under the bargaining legislation enacted in 2002.

The drop in state tax revenues for the 2003-2005 biennium had a double impact on the Basic Health program: cost-sharing was increased for members and enrollment was reduced. The enactment of Initiative 773 in 2000 was expected to fund increases in BH program enrollment above the 125,000 level. Instead, the state's budget provides for a target enrollment level of 100,000 for 2004 - fewer enrollees than at any time since June 1996. The budget also required that BH enrollees pay for a larger portion of their services – in the form of higher premiums, copayments, co-insurance, and an annual deductible. With the reduction in funded enrollment there is a waiting list in 2004 for BH coverage.

The Community Health Services program has received increases in funding in 2003 and 2004, in recognition that the role of community clinics as a health care "safety net" is becoming more important as funding is reduced for other health insurance programs.

The current outlook provides HCA a strong incentive to identify innovative strategies to reduce administrative burdens, poor quality care, and unnecessary care – as a way to reduce cost increase trends. A growing focus on quality of health care delivery may prove to lower costs as purchasers encourage providers to engage in practices that reduce harm to patients, and reduce costs. Initiatives that consolidate purchasing, particularly in the purchase of pharmaceuticals, may also prove to be fruitful. However, with the numerous factors that drive cost trends, it appears health care costs will continue to increase, even if we are successful in reducing the incidence of poor quality care. Society will continue to face the question of what portion of the cost trends should be borne by employers and taxpayers, and what portion should be paid by employees and persons covered by public programs.

G: Trends in Customer Characteristics

The increasing health care trend and the need to improve quality and efficiency within the HCA's contracted plans and providers present the greatest impact on HCA's budget. In addition, the aging of the enrollee population presents increasing demands on utilization and cost of services. The age of consumers in the PEBB programs is growing at an even faster rate than in the general population. In 1996, 41% of the PEBB active enrollees were over the age of 40. In 2004, that percentage grew to 58.9%. Also in 1996, 8% of PEBB enrollees were in Medicare. In 2004, Medicare enrollees made up 15.8% of the PEBB population.

While Medicare enrollment is not a part of Basic Health's population, the membership in that program has aged as well. In 1996, 38.3% of the subsidized population was over the age of 40. By 2004, the level grew to 46.3%.

In 1996, 121,768 uninsured people at or below 200% of the federal poverty level utilized CHS funding. In 2003, 200,376 utilized CHS funding – a 65% increase since 1996.

H: Strategy and Capacity Assessment

Two areas could have significant impacts on the Health Care Authority over the next several years, both dealing with customer expectations: the demand for more technological tools to interface with the agency's programs; and the unknown impact of collective bargaining.

As our enrollees become more sophisticated, both in the use of technology and their knowledge of health care, they expect the HCA to provide them with more tools to better understand and access their health care. Interactive tools, such as online open enrollment, continue to receive more use each year. More tools are needed to better address our customers' needs. Our development of a new system to replace the legacy systems used by PEBB and Basic Health will address demands from our sister agencies to provide Web-based interfaces to our system. The need to address these demands is likely to force an added emphasis on our technology resources.

We are not sure how collective bargaining might affect the HCA. Possible impacts include communicating different benefit packages to different groups; system modifications to adjust to negotiated benefit changes; and training of staff to handle new or multiple benefit packages. We are also likely to be called upon to offer benefit expertise during the negotiation process.

Regarding demand for services from Basic Health and CHS, our challenge is to maximize our response to the ever-increasing demand for health care, and the public's expectation for greater access.

I: Performance Assessment

Community Health Services: One of the goals of the HCA, CHS program, 2003-05 Performance Progress Report is to "Promote and assure access to health care services for the underinsured, uninsured and special populations with unique barriers to health care. To accomplish this goal, CHS provides grants to community clinics to assist them in providing primary care services (includes both medical and dental prevention and illness care). These services are targeted to people at or below 200% of the federal poverty level and have no other coverage such as Medicaid or Basic Health. Additionally, services must be provided in an appropriate cultural setting by the community clinics." To help measure the accomplishment of this goal, CHS has two performance measures. One measure is for the CHS grant funds to help serve 152,000 customers for fiscal year 2004 and 155,276 customers for fiscal year 2005. The second measure is to select at least 15 community health clinics each fiscal year for onsite monitoring to assess the accuracy of clinic information reported for funding determination and verification of services provided with grant funds.

While the CHS' performance measures can be compared to various recognized industry standards, the two standards primarily used are the Federal Industry Standard (Public Health Service Grants as modified for Washington) and the State of Washington (OFM) Client Services Contracting Guidelines. Performance targets for the above CHS goal are expected to meet these standards.

Expanding access to those clinics that do not get public health funds has been identified as one emerging issue as well as one performance improvement opportunity for the next biennium. In addition, the current performance standards are being modified to reflect increases in both funding and access.

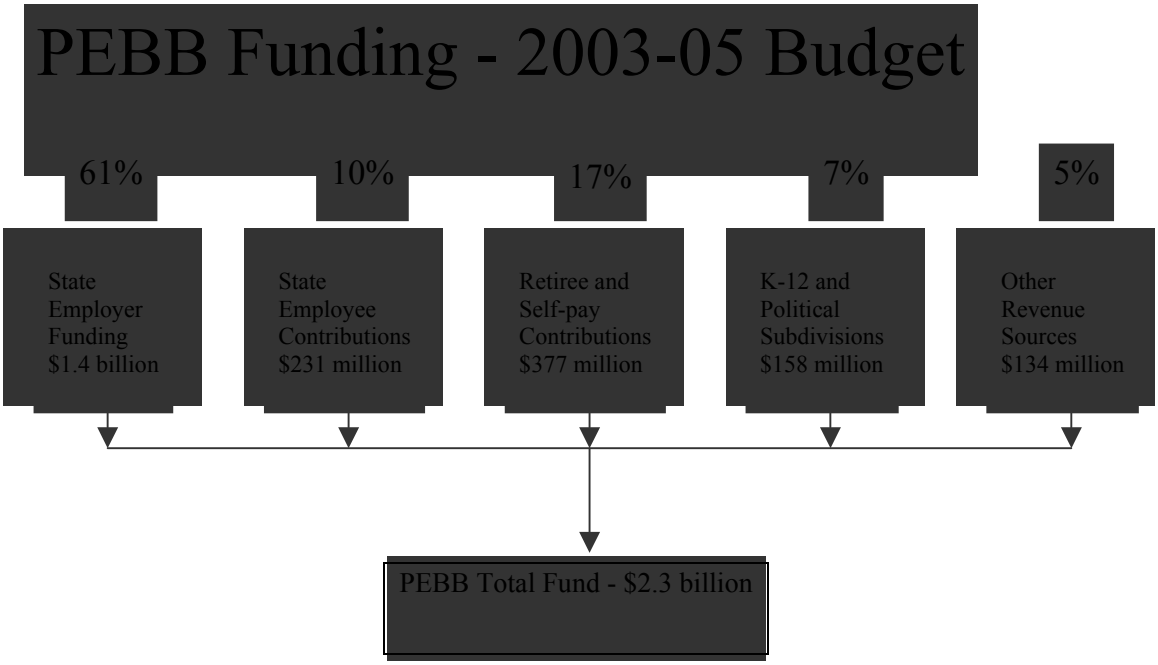
Other HCA Programs: As a performance measure, the HCA is striving to increase the percentage of BH and PEBB customer service telephone calls answered within five minutes. Recent data (January – March 2004) indicate that customer service telephone calls are being answered within 2.4 minutes which exceeds the five minutes benchmark by 2.6 minutes.

During the 2005-07 biennium, the agency will use the POG process and other evaluation opportunities to determine the most appropriate measures for its various programs, and to investigate industry standards that may apply.

J: Financial Plan Assessment

The HCA is funded by a mixture of appropriated, budgeted non-appropriated and non-budgeted funds. The sources of these funds vary by program, and are related to the purpose of the program.

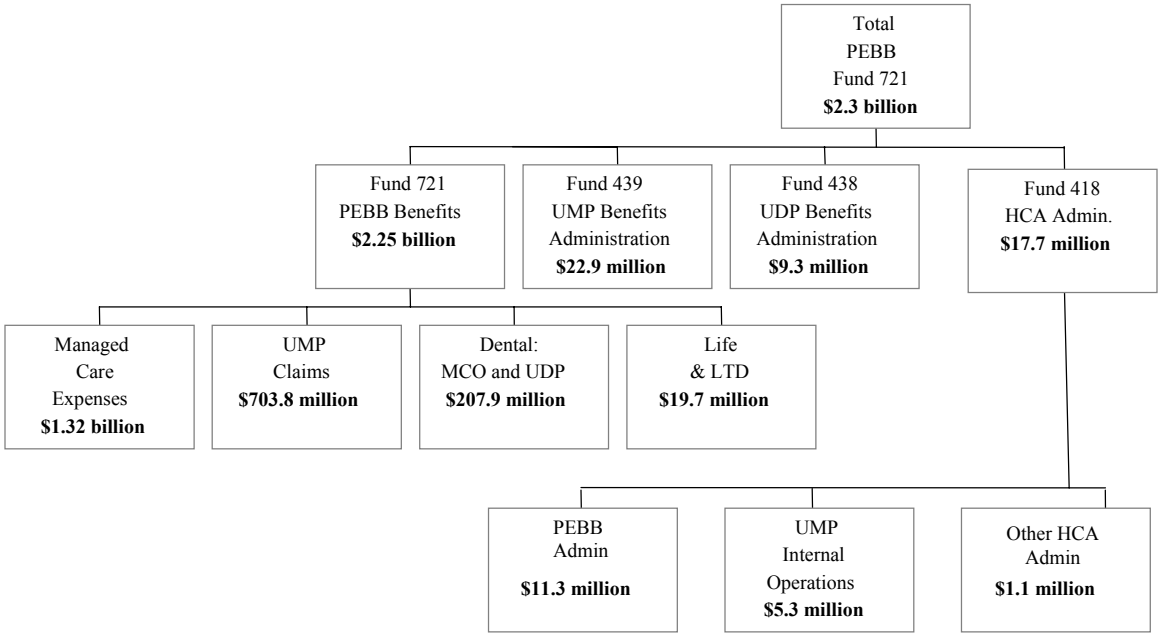
1. Public Employees Benefits Board (PEBB): Funding for benefits, direct administration, and a proportionate share of HCA program support related to the PEBB comes from the non-budgeted Public Employees and Retirees Insurance Account (Fund 721). The members, state and other public agencies, retirees and those employees who are in plans with premium costs pay monthly rates to generate revenues for this account. These rates are based on (but not always identical on a per person basis) the cost of providing insurance benefits to these various groups.



All employer provided benefit costs (medical, dental and basic life and long term disability) are paid directly from Fund 721. Medical benefits costs have continued to increase 12%-15% per year for state employees and other non-Medicare members, and up to 20% for Medicare members. More information about estimated costs for CY 05 and the 05-07 biennium will be available after the CY 05 medical procurement is concluded in June.

Administrative activities are paid through one of three budgeted sub-accounts: the HCA Administrative Account, the Uniform Dental Plan Benefits Administration Account and the Uniform Medical Plan Benefits Administration Account.

PEBB 03-05 EXPENDITURES



2. Basic Health (BH): Funding for Basic Health Administration and the state's share of benefits costs is appropriated from Fund 760, the Health Services Account. The largest appropriations from this account are for BH and portions of DSHS-Medical Assistance's Medicaid programs. Expenditures from the account have grown faster than revenues, prompting reductions to BH enrollment and state share levels in the 03-05 biennium. This is likely to be an issue again in the development of the 05-07 budget.

Revenue from premiums charged to subscribers in regular subsidized BH is deposited in Fund 172 and applied directly to their health plan costs. Costs for regular subsidized BH have been growing at about 10% per year (excluding the impact of program changes for CY 2004). More information about CY 05 and the 05-07 biennium will be available after the CY 05 procurement is concluded in early August.

The HCA had also operated a non-subsidized BH program through December 2002, in which enrollees paid the full cost of health care insurance plus a $10 administrative fee into fund 761. The implementation of a Health Care Tax Credit program for those displaced under the Federal Trade Act of 2002 (PL 107-210), through HB 2797 (Ch 192 L 2004), will be similar in nature to the non subsidized program and fund, beginning in CY 05. Approximately 1,000 people are estimated to enroll; 65% of their costs of insurance will be paid by the Federal government.

3. Other programs: HCA's Community Health Services, WSHIP subsidy program, Pharmacy Connections grant portion of the Prescription Drug Program and Health Care Planning functions are also funded from the HSA, and therefore are at some risk if projected expenditures exceed revenues to the fund.

K: Cost Reduction Strategies

The Uniform Medical Plan has begun implementing a state Preferred Drug List based on clinical evidence. The list was developed by a state Pharmacy and Therapeutics Committee that includes practicing physicians and pharmacists. It will be adopted jointly by state programs that purchase prescription drugs, including MAA, L&I, and UMP. The state Preferred Drug List was implemented by UMP for eleven drug classes effective January 1, 2004, for estimated savings of approximately $3-4 million per year. By 2006, the state Preferred Drug List will be expanded to include 25 drug classes. Use of the Preferred Drug List should create significant savings due to bulk purchasing of drugs for the various state programs.

Another major cost savings strategy affected all segments of the HCA. The agency has encouraged the use of the Internet by its program enrollees to reduce mailing and printing costs for benefit and enrollment information. Building on this focus, a team from throughout the agency investigated other ways to reduce mailing, printing, and processing costs of materials. The goal for the 2003-05 biennium was to realize $80,000 in savings. This was surpassed the first year of the biennium with savings estimated at more than $256,000. Further possible avenues for such savings will continue to be explored in the 2005-07 biennium.

L: Major Partners

Insurance Plans and Health Care Providers:
The HCA depends on seven medical insurance companies to provide high quality care for PEBB and BH members. For its PEBB enrollees, the agency also contracts with three dental plans, as well as with other companies to provide coverage for life, long term disability, long term care, automobile, and homeowners insurance. Our partnerships with the plans includes development of the annual request for proposals and any changes to our medical and dental benefits; evaluation of plan bids and coverage proposals during procurement; compliance with new requirements such as HIPAA; and contract monitoring through TEAMonitor. The Uniform Medical Plan contracts directly with health care providers, while Community Health Services program contracts with community clinics around the state through its annual grant award process. HCA staff meet regularly with health industry groups, including the Washington State Medical Association and the Washington State Hospital Association, to involve them in agency initiatives and to stay informed about industry concerns.

State Agencies
The HCA enjoys a good working relationship with its sister agencies on a variety of levels. To provide state employees with pertinent information about their benefits, the HCA works directly with both communications and payroll/personnel staff in other agencies. Similar partnerships with the Department of Retirement Systems, Department of Information Services, and the Department of Personnel help provide PEBB enrollees with benefit and other important information.

Partnerships with other agencies help Basic Health ensure that state dollars help only those eligible for the program. Relationships with Employment Security, the Department of Revenue, and the Department of Social and Health Services (DSHS), allow the HCA to verify income information provided by enrollees.

The agency's most extensive partner is the Medical Assistance Administration (MAA) division of DSHS. The two agencies work together to cross-evaluate applications for Medicaid and Basic Health. They also coordinate coverage when pregnant Basic Health enrollees are switched over to MAA's First Steps program. The two agencies have enjoyed great success in maintaining a seamless link between their programs.

The HCA and MAA also work together to minimize redundancies during the annual contract procurement process. While the various programs (PEBB, Basic Health, and MAA) develop their own unique requirements, common criteria and standards cover quality improvement, provider network access, financial status, and information reporting. For those particular sections, medical plans submit one set of documents for their bids on all three programs. Using common information also allows HCA and MAA to maintain a single database of providers which allows enrollees to search online for information about their doctors.

In addition, the HCA participates in a number of projects and initiatives in collaboration and cooperation with sister agencies:

TEAMonitor. The HCA, MAA and the Department of Health monitor health plans that contract with the state. The Medical Directors and a team from each agency monitor plan compliance with quality standards established in the procurement process. Activities include on-site audits of health plans, a detailed evaluation of each health plan's level of compliance and development of a corrective action plan to address areas of concern.

Interagency Collaboration on Prescription Drug Purchasing. The HCA is the lead agency responsible for implementing the Evidence based Prescription Drug Program created by Senate Bill 6088 (2003), which directs the HCA Uniform Medical Plan, DSHS Medical Assistance Administration fee for service programs; and the Department of Labor and Industries to cooperatively take actions to control costs without reducing the quality of care when purchasing prescription drugs. The program consists of three major components: a single state "Preferred Drug List"; a "Washington State Pharmacy & Therapeutics Committee" to make recommendations as to what drugs should be contained on that list, and an "Endorsing Practitioner – Therapeutic Interchange Process" to allow practitioners and pharmacists to participate in the program.

This collaboration between the three agencies will give the state more leverage in negotiating with pharmaceutical manufacturers for reduced administrative fees, better drug prices and improved rebates. It will also facilitate the three agencies consolidation and management of data, as well as improve utilization and clinical management across the various programs.

Clinical Outcomes Assessment Program (COAP). The HCA, in conjunction with various state health agencies, providers and other stakeholders (including the Foundation for Health Care Quality), is collecting, analyzing and disseminating health care outcome data to improve quality for the entire state population in certain high-cost, high-frequency clinical procedures (e.g. Coronary Bypass Surgery). The program goal is to promote mechanisms for providers to develop and evaluate quality improvement programs and reduce safety concerns using outcome data, while maintaining patient confidentiality.

Outpatient Prospective Payment Systems. The HCA, MAA and L&I completed an interagency project to implement an outpatient prospective payment system (OPPS) for reimbursement of outpatient facility costs for the UMP, L & I and MAA fee-for-service program. Objectives include providing uniformity in state reimbursement methodologies and providing agencies with data to analyze outpatient utilization. UMP and L&I implemented OPPS for services beginning January 1, 2002. The overall impact on UMP claims costs is expected to be a reduction of more than $3 million per year.

Agency Medical Directors Group. HCA is the lead agency on HB 1299 (2003) which says that HCA and the Agency Medical Directors Group (AMDG) will "collaborate across state agencies to identify and assess new opportunities to improve quality, promote the cost-effective purchase of health care services, and promote administrative simplification in the state's medical care financing and delivery system."

Washington State
Health Care Authority

Balanced Scorecard

The Health Care Authority (HCA) mission is to provide access to quality affordable health care.

Our vision is to deliver the best value in health care.

To accomplish our mission, we will implement the following strategies and goals:

1. **Provide the best value in health care through agency programs, initiatives and purchasing.**
2. **Provide leadership and coordination in state health care policy and purchasing.**
3. **Practice sound business principles and financial stewardship.**
4. **Make it easy to do business with the HCA.**
5. **Promote customer participation in responsible health care decision-making.**
6. **Attract, develop, retain and reward a high-performing and diverse workforce.**